

PATIENT INFORMATION

Date: _____ Primary Language: _____

Patient's Name: _____ S.S.#: _____

Sex: Male Female Age: _____ Date of Birth: _____ Marital Status: S M W D

Local Address: _____
(City) (State) (Zip)

Phone #'s: _____
(Home) (Cell) (Other)

Alt. Address: _____
(City) (State) (Zip)

Patient's Employer: _____ Occupation: _____

Employer's Address: _____ Employer's #: _____

Nearest Relative (not living in household): _____ Phone: _____

Is Illness or Injury related to: Work _____ Auto Accident _____ Slip & Fall _____ Other _____

If yes: Date of Accident: _____ Attorney Name: _____ Phone: _____

*****Driver or Passenger?** If passenger, list your own PIP insurance? _____

INSURANCE INFORMATION: MUST HAVE INSURANCE CARD

Auto Insurance Co: _____ Phone#: _____

Policy #: _____ Claim #: _____

Relation to Insured (check one): Self _____ Spouse _____ Child _____ Other _____

If not the insured, Name of Insured: _____ D.O.B.: _____

Health Insurance Co: _____ Phone#: _____

Policy #: _____ Group #: _____

Relation to Insured (check one): Self _____ Spouse _____ Child _____ Other _____

If not the insured, Name of Insured: _____ D.O.B.: _____

Release of Information and Direction to pay :

I hereby authorize South Florida Physical Therapy Associates, to release any information either pertinent to my healthcare or necessary to secure payment to any insurance company, third party, adjuster and/or attorney involved in my treatment. I hereby request that direct payment be made to South Florida Physical Therapy Associates, for any authorized medical benefits payable under my current insurance policy as payment toward the total charges for services rendered. I understand that I remain personally responsible and agree to pay any applicable deductible, co-pay or any balance not paid by my insurance carrier, third party, adjuster and/or attorney in a timely manner. If this should become a collection matter, I agree to be responsible for the cost of collection including court costs and attorney fees.

Medicare Patients only: I authorize any holder of medical or other information about me to release to CMS and its agents any information needed to determine my benefits for services rendered.

By my signature on this form, I do hereby state that to the best of my knowledge, that all information is correct.

SIGNATURE: _____ **DATE:** _____

WITNESS NAME IF ASSISTANCE NEEDED WITH FORM: _____

(PRINT)